STIs and HIV/AIDS with no prejudice. Adhering to unfounded propaganda and denial of the social realities propagates the social ills with catastrophic public health consequences.

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Clinically resistant trichomoniasis

We read with interest the recent review on trichomoniasis and would like to share our experience of a patient with clinically resistant infection, in whom various therapies were tried until we achieved a successful response.[1]

A 39 year old Irish female factory worker presented in April 2001, complaining of a copious malodorous vaginal discharge associated with vulval soreness following unprotected sexual intercourse with a casual male partner 4 months previously. On examination the vulva and groin were erythematous and there was a profuse frothy yellow vaginal discharge with a pH >4.5. Microscopy revealed *Trichomonas vaginalis* and she was treated with a 5 day course of oral metronidazole 400 mg twice daily as per the UK national guidelines.[2] Screening for chlamydia and gonorrhoea was negative.

Over the next 10 months, she re-attended a further eight times with persistent symptoms and on each occasion denied any sexual contact or non-compliance with treatment. After her third visit, a management strategy was implemented on the basis of a literature review with a named clinician. In total, she received two courses of oral metronidazole (one preceded by oral amoxicillin[2]), three courses of metronidazole suppositories (used as pessaries), a single dose of tinidazole, and a course of acetarsol and nononxynol-9 pessaries. However, despite the planned treatments microscopy was repeatedly positive. She even had her intrauterine device removed in case this contributed to the problem.

Finally, in February 2002, she was treated with oral metronidazole 400 mg three times daily and metronidazole pessaries 1 g daily for 2 weeks following the recommendations of another consultant colleague in the region. Her symptoms had resolved and microscopy was negative when reviewed 3 weeks later. She did not experience side effects secondary to the high dose metronidazole and continued 1 g pessaries once every 2 weeks for 2 months as maintenance therapy. The frequency was then reduced to every 4 weeks for 2 months and, reassuringly, microscopy remained negative. Treatment was then stopped and she has not re-attended subsequently.

Management of patients with treatment failure is challenging as sensitivity testing is currently unavailable. A key factor in this woman was her frustration with multiple therapies, which resulted in erratic attendance. Acetarsol and nononxynol-9 pessaries have been used with varying results but in our patient both were unsuccessful.[3–5] In persistent infection it is important to ascertain a patient's compliance with therapy and any possibility of re-infection, both of which were excluded. The use of extended courses of treatment has also been suggested in the management of other vaginal infections such as candidiasis and bacterial vaginosis.[2 6] Certainly, in our patient this approach was required.

The distressing symptoms associated with clinically resistant trichomoniasis cannot be underestimated, thus sharing anecdotal management experience is essential. Devising a treatment schedule and providing a named clinician to ensure continuity of care is invaluable for such patients. We would suggest that re-treating with a prolonged course of oral and vaginal metronidazole at an early stage can result in a favourable outcome and should be considered.

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A video mobile phone and herpes simplex

The use of mobile phones in today's society is pervasive, and for genitourinary medicine (GUM) attendees mobile phones as a common form of communication have been documented.[1] However, as far as we are aware, the use of a mobile phone as a diagnostic aid has not been reported.

A 35 year old black Caribbean man presented to our clinic and gave a history of having developed a collection of ''small lumps'' on his prepuce, 1 week previously. However, he had been unable to attend at that time. He reported that the lumps had improved and had crusted over. He reported no systemic symptoms. On examination there were crusted lesions consistent with healing genital herpes and no palpable lymphadenopathy. Fortunately, the patient had taken a video clip using his mobile phone when the lesions had first appeared (he had taken both a still and a video of his penis). The images were very clear and there was no doubt that this man had had an outbreak of genital herpes. As a result of the images from his video mobile phone we were able to make a confident diagnosis of genital herpes and then have an appropriate discussion with increased certainty.

A second case involved a 41 year old man who presented to the clinic because his long term partner had had an episodic rash affecting the natal cleft for the past 3 years. She had been seen by her GP and had also been referred to a local dermatology department. According to the patient the episodic rash had remained undiagnosed despite a skin biopsy having been performed by the dermatologist. He had taken a picture of the rash during an episode with his video mobile phone. This revealed the characteristic vesicles of herpes simplex infection. He himself had a distant history of genital herpes infection but had no recent recurrences. He was advised to encourage his partner to attend the clinic for further management (along with his mobile phone).

These two consultations illustrate how video mobile phones have been used in our clinic to facilitate and aid diagnosis. Dentists often send photographs via email of suspicious oral lesions to oral medicine specialists. Dermatologists are performing telemedicine consultations with GPs for the diagnosis and subsequent investigation of skin complaints.[2] The use of mobile phones within GUM services is increasing, with some clinics texting results to patients.[3] However, as far as we are aware this is the first time that patients have utilised similar technology to facilitate the diagnosis of genital lesions.

Who knows, maybe in the future, patients will phone up and use their video phones to do distant consultations with GUM physicians. And the complaint: ''It has always gone by the time a patient gets to see a doctor'' will be a thing of the past.

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